

ACADIA WELLNESS CENTRE

File # _____

The doctors and staff wish to welcome you and want to provide you with the best possible care.

Patient Information

Name: _____ Date: _____

Address: _____

Phone Home: _____ Cell: _____ Work: _____

Email Address: _____ Preferred contact: Cell / Home / Work / email

Occupation: _____ Employer: _____

AHC Number: _____ Sex: ___ M ___ F Age _____ Birthdate: _____

In case of emergency, who should we contact: Name: _____

Relationship _____ Phone Home _____ Work _____

Who can we thank for referring you? _____

Have you seen a chiropractor before? ___ Y ___ N Who? _____

Family Information

___ Single ___ Married ___ Widowed ___ Divorced

Spouse/Partner name: _____

Children: How many? _____ Ages: _____

Accident Information

Is this condition due to an accident? ___ Y ___ N

Automobile? ___ Slip or fall? ___ Work? ___

Do you have an active insurance case? ___ Y ___ N

Are you starting an insurance case? ___ Y ___ N

Symptom Questionnaire

What brings you in today?

1) _____

Severity of pain 1 2 3 4 5 6 7 8 9 10

What do you think caused this complaint? _____

What makes it better? _____

What makes it worse? _____

2) _____

Severity of pain 1 2 3 4 5 6 7 8 9 10

What do you think caused this complaint? _____

What makes it better? _____

What makes it worse? _____

3) _____

Severity of pain 1 2 3 4 5 6 7 8 9 10

What do you think caused this complaint? _____

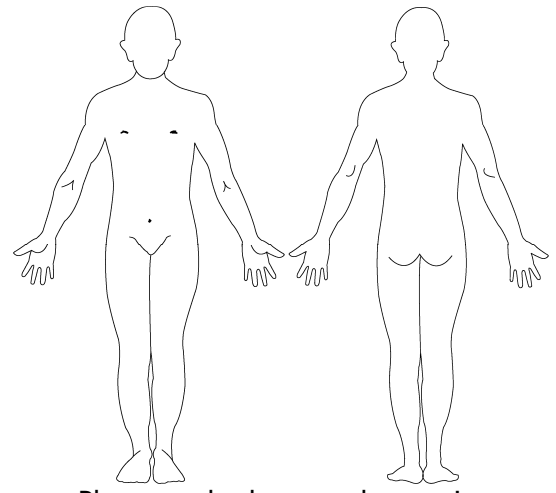
What makes it better? _____

What makes it worse? _____

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Describe the pain: ___ Sharp (knife like) ___ Dull (like a toothache)
 ___ Burning (hot) Other: _____
 What time of day is the pain the worst?
 ___ Morning ___ Afternoon ___ Evening ___ Night ___ All the time
 The pain is ___ Occasional ___ Frequent ___ Constant.
 Is the pain local ___ Y ___ N
 Does the pain travel or radiate down the arm or leg? ___ Y ___ N
 How far? _____
 Do you have any ___ pain, ___ numbness, ___ tingling, ___ pins and
 needles in the ___ hands or ___ feet. ___ Y ___ N
 Does this pain affect your sleep? ___ Y ___ N



Please mark where you have pain.

Social History

Height _____ Weight _____
 How much Alcohol do you drink per week? _____
 How much coffee do you drink a day? _____
 How much soda do you drink a day? _____
 Do you love sweets? ___ Y ___ N Do you crave salt ___ Y ___ N
 Do you smoke? ___ Y ___ N Do you stretch daily? ___ Y ___ N
 How many times a week do you exercise? _____
 What type of exercise do you do? _____
 How would you rate your daily stress level? L 1 2 3 4 5 H

Physical History

Please describe and date:
 Any Falls: _____

 Any Accidents: _____

 Any Broken Bones: _____

 Any Surgeries: _____

 Any hospitalizations: _____

Health History

Please mark anything that applies to you either presently, in the past or no at all.

	Present, Past, No		Present, Past, No		Present, Past, No		Present, Past, No
AIDS/HIV	_____	Dizziness	_____	Liver Disease	_____	Psychiatric Care	_____
Alcoholism	_____	Emphysema	_____	Loss of Balance	_____	Rheumatoid	_____
Allergies	_____	Epilepsy	_____	Measles	_____	Arthritis	_____
Anemia	_____	Fainting	_____	Menstrual	_____	Rheumatic Fever	_____
Anorexia	_____	Fractures	_____	Difficulties	_____	Scarlet Fever	_____
Appendicitis	_____	Glaucoma	_____	Migraine	_____	Stroke	_____
Arthritis	_____	Goiter	_____	Headaches	_____	Thyroid Problem	_____
Asthma	_____	Gonorrhoea	_____	Miscarriage	_____	Tonsillitis	_____
Bleeding	_____	Gout	_____	Mononucleosis	_____	Tuberculosis	_____
Disorders	_____	Heart Disease	_____	Multiple Sclerosis	_____	Tumours/Growths	_____
Breast Lumps	_____	Hepatitis	_____	Mumps	_____	Typhoid Fever	_____
Bronchitis	_____	Hernia	_____	Nervousness	_____	Ulcers	_____
Bulimia	_____	Herniated Disc	_____	Osteoporosis	_____	Vaginal Infections	_____
Cancer	_____	Herpes	_____	Pacemaker	_____	Venereal Disease	_____
Cataracts	_____	High Blood	_____	Parkinson's	_____	Whooping Cough	_____
Chemical	_____	Pressure	_____	Disease	_____		
Dependency	_____	High Cholesterol	_____	Pinched Nerve	_____	Hysterectomy	Yes No
Chicken Pox	_____	Immunizations	_____	Pneumonia	_____	Are you Pregnant	Yes No
Diabetes	_____	Irritability	_____	Polio	_____	Date of last Period	_____
Difficult Urinating	_____	Kidney Disease	_____	Prostrate Problem	_____		

ACADIA WELLNESS CENTRE

MEDICAL SPECIALIST

Name: _____ Phone: _____

Specialty: _____ Date of Last Appointment: _____

DENTIST

Name: _____ Phone: _____

Location: _____ Date of Last Appointment: _____

DENTAL SPECIALIST

Name: _____ Phone: _____

Specialty: _____ Date of Last Appointment: _____

List Past Dental Procedures: _____

NATUROPATH

Name: _____ Phone: _____

Location: _____ Date of Last Appointment: _____

MASSAGE THERAPIST

Name: _____ Phone: _____

Location: _____ Date of Last Appointment: _____

PHYSICAL THERAPIST

Name: _____ Phone: _____

Location: _____ Date of Last Appointment: _____

Other Specialist / Practitioner

Name: _____ Phone: _____

Location: _____ Date of Last Appointment: _____